# Patient Medical History

Patient: ______________________________ Date:________________________________________

Telephone#: ________________________ Referring Physician: ____________________________

**MEDICAL INFORMATION: TO THE BEST OF YOUR KNOWLEDGE, DO YOU HAVE/HAVE HAD:**

| # | Condition | | | # | Condition | | |
|---|---|---|---|---|---|---|---|
| 1. | High Blood Pressure | **yes** | **no** | 25. | Thyroid Problems | **yes** | **no** |
| 2. | Chest Pains/Angina/Heart Attack | **yes** | **no** | 26. | Polio/Muscle Disease | **yes** | **no** |
| 3. | High Cholesterol | **yes** | **no** | 27. | Seizures | **yes** | **no** |
| 4. | Pacemaker | **yes** | **no** | 28. | Chronic/Migraine Headaches | **yes** | **no** |
| 5. | Shortness of Breath | **yes** | **no** | 29. | TMJ Disorders | **yes** | **no** |
| 6. | History of Smoking | **yes** | **no** | 30. | Chills/Fevers Sweats | **yes** | **no** |
| 7. | Lung Problems | **yes** | **no** | 31. | Swelling of Extremities | **yes** | **no** |
| 8. | Emphysema/Asthma | **yes** | **no** | 32. | Osteoporosis | **yes** | **no** |
| 9. | Bleeding/Bruising | **yes** | **no** | 33. | Depression | **yes** | **no** |
| 10. | Anemia | **yes** | **no** | 34. | Fibromyalgia | **yes** | **no** |
| 11. | Diabetes | **yes** | **no** | 35. | Chronic Fatigue Syndrome | **yes** | **no** |
| 12. | Hypoglycemia | **yes** | **no** | 36. | Lyme's Disease | **yes** | **no** |
| 13. | Lightheadedness/Dizziness | **yes** | **no** | 37. | Cancer/Tumors/Growths | **yes** | **no** |
| 14. | Blood Disorders | **yes** | **no** | 38. | Are you pregnant? | **yes** | **no** |
| 15. | Concussion | **yes** | **no** | 39. | Gynecological Disorders | **yes** | **no** |
| 16. | Fainting Disorders | **yes** | **no** | 40. | Bladder Incontinence | **yes** | **no** |
| 17. | Anxiety/Panic Attacks | **yes** | **no** | 41. | Bowel Incontinence | **yes** | **no** |
| 18. | Arthritis/Joint Pain | **yes** | **no** | 42. | Diarrhea/Nausea/Vomiting | **yes** | **no** |
| 19. | Artificial Joints | **yes** | **no** | 43. | Unexplained Weight Loss >10 lbs./last30days | **yes** | **no** |
| 20. | Kidney Disease/Stones | **yes** | **no** | 44. | **UNDER 18 ONLY:** | | |
| 21. | Hepatitis | **yes** | **no** | | Immunizations Current | **yes** | **no** |
| 22. | Spinal Cord Injury | **yes** | **no** | | | | |
| 23. | Traumatic Brain Injury | **yes** | **no** | | | | |

24. Fractures:
Date: ________________Area:______________________________________________________

Date: ________________Area:______________________________________________________

Do you have a history of back/neck pain? YES NO
When? ____________________________________
Do you have any metal implants? YES NO
Where? ____________________________________
Do you smoke? YES NO
How much per day? _________________________
Do you exercise regularly? YES NO
How often? _________________________________
Do you have any known drug allergies? YES NO
Please list __________________________________
Are you pregnant or suspect pregnancy? YES NO

**In regards to your current condition:** (Please rate your pain)

0 1 2 3 4 5 6 7 8 9 10
***no pain*** ***worst pain***

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| | | |
|---|---|---|
| Do you have any "pins and needles" or numbness in your extremities? | YES | NO |
| Do you have any weakness in your arms or legs? | YES | NO |
| Do you have any coordination or balance problems? | YES | NO |
| Do you have difficulty walking? | YES | NO |
| Do you experience dizziness or vertigo with a change in position? | YES | NO |
| Have you experienced headaches as a result of your condition? | YES | NO |
| Were you injured in a work related incident? | YES | NO |

**Please list all current medications:**

_______________________________________________________________________________

_______________________________________________________________________________

**Please list all surgeries/date:**
**(Use back of page if necessary)**

_______________________________________________________________________________

_______________________________________________________________________________

**Please check recent diagnostic tests performed**: ( ) X-Ray ( ) MRI ( ) CT Scan ( ) Bone Scan ( ) Bone Density ( ) EMG ( )Ultrasound

**Please describe your chief complaint and current condition**:_______________________________________________________________________

_______________________________________________________________________________

I believe all information to be true and complete:

Signature______________________________________________________Date:_____________

Therapist Signature:______________________________________________Date:_____________


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